ES-3100
Rev. 1-09

Kansas Department of Social and Rehabilitation Services
Application for Benefits for Families

This is your application for the programs and services we offer. Answer all of the questions to the best of your ability. If English is not your preferred language, an interpreter will be provided at no cost to you.

Agency Use Only
Date Received: _____
Date Interviewed: _____
____ Initial _____ Review
Worker: _____
Case Number(s): _____

This form provides us with the information we need to determine eligibility for you and your family. The following are the programs and services you can apply for with this form:

Food Assistance: Food Assistance is electronic benefits you can use to buy food. If you need help buying food fill out all of the sections where you see the shopping cart. You may be eligible to receive food assistance within 7 days.

Cash Assistance: Cash assistance helps families and pregnant women. To apply for cash, fill out all of the sections where you see the dollar sign.

Child Care Assistance: The child care subsidy program provides benefits to help pay child care costs. To apply for child care, fill out all of the sections where you see the woman and child.

Medical Assistance: Medical assistance programs provide medical coverage for families and pregnant women. Medical coverage may help pay medical bills, doctor's visits and medicine. To apply for medical, fill out all of the sections where you see the medical bag.

Follow these steps to apply.

- Complete this form or go on-line at www.srskansas.org to apply. If you need help or have questions call 1-888-369-4777.
- Read the questions carefully and answer honestly. If you are applying for someone else, please answer the questions for that person.
- Be sure to sign and date this form. Your application is not complete until it is signed.
- If you can't complete the application right now, give your name, address, and signature on Page 1 and return the form. We need all of the information to see if you can get the help you request.
- Return this form as soon as possible. If you are eligible, some benefits start from the date a signed application is received in our office.
- Mail, fax or bring this form to your local SRS office. It may take 30 to 45 days before your application is processed.
- If an interview is required, we will contact you.
- A list of items we may need from you is on the last page of this form. Please tear off and keep for your records.

Other services: SRS also offers the services listed below. If you would like more information or to apply, please check the appropriate box.

☐ **Child Support Enforcement** - To enforce child support orders and to help assure that children have access to financial support and health care.

☐ **Vocational Rehabilitation** - To help persons with disabilities become employed.

Return this form to:

A. Help Us Decide If You Can Get Food/Medical Assistance Faster

If you have little or no money, we may be able to get you food assistance within 7 days. If you are pregnant, we may be able to get you a medical card within 10 days. Complete this section to help us decide if you can get benefits faster.

Agency Use Only

Expedited FS? ☐ No ☐ Yes

Expedited Medical? ☐ No ☐ Yes

1. Is anyone in your household pregnant?
   ☐ No ☐ Yes If yes, list name and due date: _____
   _____
2. Will your household's gross income for the month be less than $150?
   ☐ No ☐ Yes
3. Does your household have less than $100 in cash, checking, and savings?
   ☐ No ☐ Yes
4. Is anyone in your household a migrant or seasonal farm worker?
   ☐ No ☐ Yes
5. Enter your current rent/mortgage amount ..... $_____
6. Enter your current monthly utilities amount ..... +$_____
7. Shelter Expenses Total (add lines 5 & 6) ..... =$_____
8. Enter your household's gross income expected this month ..... $_____
9. Enter your household's total money in cash, checking & savings ..... +$_____
10. Expected Income & Resources Total (add lines 8 & 9) ..... =$_____
11. Are your household's shelter expenses (line 7) more than your household's expected gross income and resources (line10)?
    ☐ No ☐ Yes

B. Special Services

If you have ever been a victim of domestic violence or sexual assault, you may be eligible for special considerations and services. If you want to find out about these services and have a confidential interview, check this box. ☐

C. Tell Us About Yourself and the People in Your Home

For which program(s) are you applying? Check all that apply.

☐  Food Assistance

☐  Child Care Assistance

☐  Cash Assistance

☐  Medical Assistance

Provide the following information and sign this section of the application.

Name: _____ **Signature:** _____
First Name, Middle Initial, Last Name

Street Address: _____ City: _____ County: _____ Zip: _____

Mailing Address: _____ City: _____ County: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____ E-mail: _____

Are You: ☐ Single ☐ Married(Includes Common Law) ☐ Divorced ☐ Separated ☐ Widowed ☐ Unmarried Partnership

C. Tell Us About Yourself and the People in Your Home (continued)

Benefits depend on who lives in your household and how they are related to you. Tell us about yourself first. Then tell us more about you and everyone in your household in the boxes below and on the next page. **Use additional information sections on pages 9 or 11 if there are more than 6 persons in your household.**

First Name, MI Last Name	Relation to You	Are you applying for this person?	Sex M/F	Birth Date	Social Security Number (optional for child care)	Race/Ethnic Group (optional) **Use codes below** Race	Ethnicity		City and State of Birth/ Citizenship Status (List place of birth and check one box.)
	Self	☐ No ☐ Yes	☐ M ☐ F					City and State of Birth ______ ______ ☐ Citizen ☐ Noncitizen
		☐ No ☐ Yes	☐ M ☐ F					City and State of Birth ______ ______ ☐ Citizen ☐ Noncitizen
		☐ No ☐ Yes	☐ M ☐ F					City and State of Birth ______ ______ ☐ Citizen ☐ Noncitizen
		☐ No ☐ Yes	☐ M ☐ F					City and State of Birth ______ ______ ☐ Citizen ☐ Noncitizen
		☐ No ☐ Yes	☐ M ☐ F					City and State of Birth ______ ______ ☐ Citizen ☐ Noncitizen
		☐ No ☐ Yes	☐ M ☐ F					City and State of Birth ______ ______ ☐ Citizen ☐ Noncitizen

Race/Ethnicity Codes: The following codes are for federal reporting purposes and will not affect your benefits.

Race (choose as many as apply): A = American Indian/Alaskan Native B = Black/African American P = Native Hawaiian/Pacific Islander S = Asian W = White

Ethnicity (choose only one): H = Hispanic or Latino N = Not Hispanic/Latino

1. Is anyone getting, or has anyone received cash, food, medical or child care assistance, or tribal commodities in this or another state? ☐ No ☐ Yes If yes, complete the following:
   What benefits: ______________________ State: ______________ Month/Year: ______________

2. Is anyone in your home disabled?
   ☐ No ☐ Yes If yes, please list name and disability: ______________________________

3. Are any household members out of the home?
   ☐ No ☐ Yes If yes, list name(s): ______________________________
   Why are they out of the home? ______________________________
   Date expected to return: ______________________________

C. Tell Us About Yourself and the People in Your Home (continued)

4. Are any household members affiliated with a Native American Tribe? ☐ No ☐ Yes If yes, what tribe? _____
   Does your household live on a reservation? ☐ No ☐ Yes

The following questions are required by federal or state law for the purposes of the food and cash assistance programs only. If you answer yes to any of the questions below, make sure that you list the name(s) of the person(s) involved.

5. Has anyone in your household been convicted of a drug-related felony occurring after August 22, 1996?
   ☐ No ☐ Yes If yes, list name(s): _____

6. Is anyone in your household fleeing from felony prosecution or jail?
   ☐ No ☐ Yes If yes, list name(s): _____

7. Is anyone in your household in violation of probation or parole?
   ☐ No ☐ Yes If yes, list name(s): _____

D. Tell Us How You Want Us To Communicate With You

We provide interpreter and translation services. Complete this section to help us meet your needs. Does anyone in your household prefer to speak or read a language other than English? ☐ No ☐ Yes
If yes, write in the names of spoken and/or written language preferred below. Also include other communication needs such as braille, relay, signed English, TDD/TTY, Large Print, Voice Synthesizer Program, etc.

Name	Spoken Language	Written Language	Other Needs

E. Do You Want To Choose Someone To Help Get Your Benefits?

If you wish, you can have someone help you get your benefits. This person can fill out your application, answer questions for you, give information at your interview, and use your Vision card. This person will be your authorized representative. We will be able to share information with this person. If you choose to have someone help you, fill in the boxes below with their information:
Name:_____ Telephone Number: _____
Address: _____ City: _____ State: _____ Zip Code: _____

F. Who Eats With You

Food assistance households are based on persons who live together and who buy and cook food together.
Do you (or will you after approval) buy and cook food separately from other people in your home? ☐ No ☐ Yes
If yes, please list their names and relationship to you: _____
_____

G. Tell Us About Students In Your Home

Special rules apply to students. Complete this information to help us decide if these rules apply to your household.
Is anyone in your home a student in high school, college, or vocational-technical school?
☐ No ☐ Yes If yes, complete the following:

Student Name	Grade	Name of School	PT - Part Time FT- Full Time

H. Tell Us About the Parents of Each Child in Your Home

We need to know how the people in your household are related. List name of each child, and the names of both parents - even if the parents do not live together. For unborn children, write "unborn". If you need more room, use page 9 or 11.

Child's Name/ Unborn Child	Mother's Name	Father's Name	Was the mother married to the father when the child was born?
1.			☐ No ☐ Yes
2.			☐ No ☐ Yes
3.			☐ No ☐ Yes
4.			☐ No ☐ Yes

I. Tell Us About Parents Not Living In the Home

To get cash or child care assistance, you must cooperate with Child Support Enforcement (CSE). **If this would put you or your child(ren) in danger of abuse, or if you have other good reasons why you cannot cooperate, please tell us.**

Are there any children in your household who have an absent parent (parent not living in the home)? ☐ No ☐ Yes

If yes, list each child's name or number (see Section H above) and fill out the information for the absent parent in the columns below if known. If you need more room, use page 9 or 11.

	Child's Name/Number	Child's Name/Number	Child's Name/Number	Child's Name/Number
Provide the following information for the **absent parent**				
	List Absent Parent Information Below the Child's Name.			
Name				
Date of Birth				
Address				
SSN				
Employer Name				
Reason not in home				
Date of Last Contact. If divorced, case # and court where filed				
Will you help CSE begin/ enforce support order for each child?	☐ No - tell us why below ☐ Yes	☐ No - tell us why below ☐ Yes	☐ No - tell us why below ☐ Yes	☐ No - tell us why below ☐ Yes

If you answered no to the last question, tell us why: _____

_____

_____

J. Tell Us About Your Resources

We need to know about your resources to decide if you can get benefits. Does anyone in your household have a trust fund?
☐ No ☐ Yes If yes, we may be contacting you for more information.

Please complete the rest of this section if you want food or cash assistance. If you only want medical assistance, go on to Section K, Earned Income, below.

Does anyone in your household own or have their name on any resources? For example: cash, checking/savings/credit union accounts, certificates of deposit (CD's), stocks, bonds, IRA's, property or any other resources?
☐ No ☐ Yes If yes, complete the following information. If needed, use page 9 or 11 to list more information.

Type of Resource	Name(s) on Resources	Where is Resource Held? (Name of Bank, Credit Union or Company)	Amount or Value

K. Tell Us About Your Earned Income

We need to know about all income from jobs, self-employment, contract labor, etc. Is anyone in your household self-employed or working at a job?
☐ No ☐ Yes If yes, complete the information below for all jobs. Self-employment includes earnings from odd jobs, child care, lawn mowing, snow removal, cosmetic sales, etc. If needed, use page 9 or 11 to list more information.

Name	Employers Name, Phone & Address (if self-employed, list type of business)	Salary or Hourly Wage	Tips or Commission	Weekly Hours Worked	How often do you get paid?	Day of the week paid

Has anyone in your household lost or quit a job in the last 60 days? ☐ No ☐ Yes Name(s): _____

Employer: _____ Last Work Day(s): _____ Reason(s): _____

L. Tell Us About Your Other Income

We also need to know about all other income in your household to decide if you can get benefits.

Does anyone in your household, including children, get other income - such as child support, Social Security, SSI, VA, workers compensation, unemployment benefits, other pension/retirement, money from others, or any other income? ☐ No ☐ Yes
If yes, fill out the information below for all types of income. If needed, use page 9 or 11 to list more information.

Type/Source of Income	Name of Person Who Receives This	Amount Received	How Often Received

Has anyone applied for other income or benefits? ☐ No ☐ Yes

If yes, list who and what income or benefits: _____

M. Tell Us If You Have Child Care Needs

To help us decide if you can get child care benefits, tells us why you need help with child care expenses (check all that apply) :

☐ I have a job

☐ I go to school/training

☐ Other - Explain: _____

Do you need help finding quality child care? ☐ No ☐ Yes

Please fill out the information below for each child who needs child care. Use page 9 or 11 if child care is needed for more than 4 children.

	Child's Name	Child's Name	Child's Name	Child's Name
Provide the following information for each child who needs child care.				
	List Child Care Provider Information Below Each Child's Name			
Child Care Provider's Name				
Business Name (if different)				
Address				
Phone Number				
List Hours Child Care Needed				
Is the child in school?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, fill out below				
Grade				
Name of School/ Headstart				

Agency Use Only

N. Tell Us About Your Medical Bills and Health Insurance

If you are applying for medical assistance, complete this section to help us decide what medical expenses we can help you with.

1. Does anyone you are applying for have unpaid medical bills from the past three months?

   ☐ No ☐ Yes If yes, list total amount: _____

2. Do you want eligibility determined for the past three months?

   ☐ No ☐ Yes

3. Does anyone you are applying for have health insurance of any kind (other than Medicaid and/or HealthWave)?

   ☐ No ☐ Yes If yes, fill out the chart below and provide copies of your insurance card(s) - (both sides.)

Name of Insurance	Policy Holder	Persons Covered	Type of Coverage	End Date	Policy and Group No.

4. If health insurance has ended in the past six months for anyone you are applying for, please explain why:

_____

O. Tell Us About Your Household Expenses

To help us decide the correct amount of food assistance benefits, tell us about your shelter and other expenses.

Type of Expense	Amount	Who Pays?
Do you rent your home? ☐ No ☐ Yes If renting, list landlord's name, address and phone: _____ _____		
Do you own or are you buying your home? ☐ No ☐ Yes		
What is the amount of your monthly rent or house payment?	$	
If renting, is this subsidized housing, Section 8, HUD, other? ☐ No ☐ Yes		
If yes, tell us the amount you are obligated to pay each month	$	
Do you pay property taxes not included in house payment? ☐ No ☐ Yes	$	
Do you pay homeowner's insurance not included in house payment? ☐ No ☐ Yes	$	
Do you pay child or dependent care? ☐ No ☐ Yes	$	
Do you pay child support? ☐ No ☐ Yes List amount paid and court order number for each child: _____	$	
If you are 60 or older, or disabled, do you have any medical expenses? ☐ No ☐ Yes Include health insurance and Medicare Premiums. Use page 9 or 11 to list more information.	$	
Do you have any utility expenses? ☐ No ☐ Yes		
Do you have a heating or cooling expense? ☐ No ☐ Yes		

If no, check the following utilities you are responsible to pay:

☐ Water ☐ Sewer ☐ Trash ☐ Telephone ☐ Electricity/gas for cooking or lights ☐ Other _____ ☐ None

Have you received Low Income Energy Assistance (LIEAP)? ☐ No ☐ Yes If yes when: _____

Does any one help you pay the above expenses? ☐ No ☐ Yes If yes, what expenses do you get help with?

_____ How much do they pay? _____

Please read this information before signing Page 10

Rights, Responsibilities, and Penalties

- I have read and understand my rights and responsibilities listed on the tear off page at the end of this form.
- I understand the questions on this application form.
- I understand the penalties for hiding information (penalties are shown on the tear off page at the end of this form).
- I understand the penalties for giving false information (penalties are shown on the tear off page at the end of this form).

Citizenship Status

- Signing this form means that I agree everyone living in my home who is asking for assistance is a U.S. citizen or is in legal immigration status. I understand this requirement does not apply to persons asking for Emergency Medical Assistance (SOBRA Program).

Changes You Must Report

- I agree to report changes such as changes in my address, income changes, changes in child care, and changes in individuals who live in my home.
- I understand my worker will send me a notice about the changes I am required to report.
- I will let my worker know of changes that might affect my eligibility or benefit level.

We Will Verify the Information You Give Us

- I understand you will verify the information I provide on this application form.
- I understand you may contact other agencies such as federal, state, local officials, employers, medical providers, businesses, financial organizations, and child care providers to verify information.
- I understand you will use the information you verify and that it could affect my eligibility or benefit level.

Information about Social Security Numbers

- I understand that I have to provide or apply for a Social Security Number for people in my household who are asking for assistance.
- I understand Social and Rehabilitation Services (SRS) and the Kansas Health Policy Authority (KHPA) use Social Security Numbers to operate. The numbers are used for computer matches with the Social Security Administration, banks, the Internal Revenue Service, and other organizations and agencies.

Information about Child Support Enforcement

- I agree to help Child Support Enforcement (CSE) go after support for the children in my home. I will help CSE establish and enforce support orders for the children.
- I agree to give all alimony and/or child support to SRS for each person in my home receiving cash assistance.
- For medical assistance, I understand this rule only applies to me if both adults and children are found eligible for assistance.

Information about Food Assistance Expenses

- I understand I must report and verify my household expenses or I will not get a deduction for them.

Information about Work Program Cooperation

- I agree that everyone applying for and getting cash assistance will cooperate with work requirements unless exempt.
- I agree that everyone getting food assistance will cooperate with work requirements, unless exempt.
- I understand we may not get cash assistance if someone does not cooperate.
- I understand that the person who does not cooperate may also not get food assistance.

Continued on page 9

Information about Medical Assistance Coverage

- I understand the Kansas Health Policy Authority (KHPA) is responsible for administering the medical assistance program.

Third Party Resources

- I understand that the Kansas Medical Assistance Program (Title XIX and Title XXI) will only pay for services not covered by other insurance or other third parties.
- I am responsible for using and reporting all third party resources for everyone in my home who receives medical assistance. Examples of third party resources are health insurance coverage, a court settlement, medical support payments, a trust, or a conservatorship. These sources may be legally responsible for paying some of the medical expenses of a person.
- I understand that you may not pay for medical services if you believe a third party resource was not used first.
- I agree to help you go after all third party resources. The Medical Subrogation Unit goes after other parties for payment of medical services. I will help this unit pursue all third party resources.

Payments and Support

- If we are approved for medical assistance, we agree to let payments for medical services go directly to our physicians and other medical providers.
- If we are approved for medical assistance, we will turn over to the Kansas Health Policy Authority (KHPA) any medical support payments we get.

Estate Recovery Provisions - The following DOES NOT apply to the Medicare Saving Programs.

- If anyone receives medical assistance after the age 54 or while in an institution, I understand there may be a claim against the estate of the recipient or spouse to recover the medical expenditures made on their behalf.
- I understand you will tell all of our financial institution(s) and other investment companies about your pending claim on the estate.

Health Department Referral

I give my permission for my name and the names of those on my case, our address, telephone number, and eligibility status to be given to medical providers and local health departments so that they may give us information about services they provide.

☐ No ☐ Yes

Information about the Lifeline Telephone Program

- For cash (Temporary Assistance for Families and the Grandparents as Caregivers Programs only) and food assistance, I agree that SRS may provide my name, address and telephone number to telephone companies participating in auto enrollment in the Lifeline Program. The Lifeline Program provides basic telephone service at a reduced rate.
- I understand that my information is confidential and will only be used for enrollment in the Lifeline Program.
- I understand that this program is not mandatory and that I may decline this service by contacting my local telephone company.

Continued on page 10

Use this space to write additional information.

Permission to Release Information and Signature

My signature on this application authorizes employers, child care providers, health care providers, financial institutions, insurance providers, benefit providers, and other persons or agencies with knowledge of my circumstances to release to the Kansas Department of Social and Rehabilitation Services (SRS) and to the Kansas Health Policy Authority (KHPA) any information, including confidential and health information, necessary to establish my eligibility for benefits or to administer any program (including Child Support Enforcement) for which I applied.

I authorize SRS and KHPA to share medical information for administrative purposes with other agencies and contractors.

I understand all information provided on this application and all information provided to SRS or KHPA staff on my behalf is protected by state and federal confidentiality laws.

This release is valid from the date of signature set out below and shall remain valid until revoked in writing by the undersigned. A copy of this authorization is as valid as the original.

I certify under penalty of perjury that my answers are correct and complete to the best of my knowledge.

Your Signature	Date
Your Spouse's Signature or another adult in your home (Not Required)	Date
Signature of First Witness (if "X" is used)	Date
Signature of Second Witness (if "X" is used)	Date
Signature of Court-Appointed Guardian/Conservator (if applicable)	Date
Signature of Medical Representative (if applicable)	Date

Kansas Voter Registration Information

This section will not affect the assistance or services that you can receive from SRS or KHPA. If you do not check any of the boxes, you will be considered to have decided not to register to vote at this time.

Would you like to register to vote today? ☐ No ☐ Yes ☐ Already registered where I live now.

SRS and KHPA will be glad to help you with the voter registration application. If you have additional questions or need to report a problem, you may contact your county officer, Secretary of State's office, or call 1-800-262-VOTE (8683).

Use this space to write additional information.

Kansas Department of Social and Rehabilitation Services
Application for Benefits for Families
Rights and Responsibilities - Read and Tear Off for Your Records

Processing times for your application are:

- within 30 days for child care and food assistance;
- within 45 days for cash and medical assistance.

If you are eligible, benefits will start from the date a signed application is received in the SRS office.

You may be able to get food assistance within 7 calendar days if you qualify. We will let you know if you qualify for this special processing.

The following information applies to all programs: 

Your Responsibilities:

You have a responsibility to:

- provide all information needed to determine your eligibility;
- report changes as required - we will tell you what must be reported (examples include pregnancy, birth of a baby, someone leaving or moving into your house, a new job, change of income, new address, etc.);
- turn alimony and child support payments over to SRS if you receive cash assistance, and cooperate with Child Support Enforcement (CSE) if you receive cash assistance (TAF) or child care assistance;
- pay your child care provider for services;
- use, and report to SRS, any resources that could help pay for your family's medical expenses (examples include insurance policies, money won through lawsuits, or medical support payments)(medical assistance only);
- cooperate with Quality Assurance staff if your case is reviewed; and
- look for a job and participate in work related services, starting from the date that you apply for cash assistance.

Your Rights:

You have a right to:

- have an interpreter provided at no cost if English is not your preferred language;
- have information given to SRS kept confidential, unless directly related to the administration of SRS programs;
- withdraw your application at any time;
- request a fair hearing within 30 days for cash, child care, and medical assistance, or within 90 days for food assistance if you disagree with the decision;
- have your benefits determined from the date this application is received by SRS;
- special considerations and confidential services, if looking for a job or pursuing child support puts you in danger of domestic violence or sexual assault; and
- In accordance with Federal Law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.
- To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). Write HHS, Director, Office of Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY). USDA and HHS are equal opportunity providers and employers.

SRS Rights:

SRS has a right to:

- use the information on this application, including the Social Security Number (SSN) of each person in your home, to decide whether your household can get benefits. We will verify this information through computer matching programs. This information will also be used to make sure you are getting the correct amount of benefits. For child care assistance only, SSN is voluntary;
- deny benefits to your household if you do not provide requested information;
- disclose the information on your application to other federal and state agencies for official examination, and to law enforcement officials for the purpose of catching people who are running from the law. You or members of your household will not, however, be reported to the Bureau of Immigration & Customs Enforcement (formerly INS);
- refer the information on this application to federal and state agencies, as well as private claims agencies, for claims collection if overpayments arise against your household;
- conduct a full investigation of your eligibility including contacting employers, child care providers, banks, doctors, or by visiting your home; and
- deny your application or prosecute you for fraud if you knowingly give us false information so you can receive assistance.
- give information to the Kansas Health Policy Authority to administer medical assistance.

Penalties

You should also know that:

Families may lose benefits for not cooperating with the following agency programs:

- **Child Support Enforcement - establishing a child's paternity and collecting child support. (Does not apply to Food Assistance)**
- **Work Programs - looking for work, preparing for employment, and keeping a job. (For Food Assistance, only the person who does not cooperate may lose benefits.)**

Any member of your household who intentionally breaks the following rules may not get cash or food assistance for one year for the first offense, two years for the second offense, and permanently for the third offense. If you are applying for food assistance you may also be fined up to $250,000 and/or jailed up to 20 years, as well as barred from the Food Assistance Program for an additional 18 months if court ordered, may lose deductions, and may be prosecuted under other laws.

- **Do not lie or hide information to get benefits that your household should not get.**
- **Do not use food assistance benefits to buy nonfood items, such as alcohol or cigarettes, or to pay on credit accounts.**
- **Do not use, or have in your possession, Vision Cards that are not yours.**
- **Do not trade or sell Vision Cards, or use someone else's card.**
- **If you buy, sell, or trade more than $500 in food assistance benefits, you may be barred permanently from the Food Assistance program. If a court of law finds you guilty of trading food assistance benefits for firearms, ammunition, explosives, or controlled substances, you will be subject to:**
  - **loss of benefits for two years for the first offense, and permanently for the second offense involving the sale of a controlled substance; and**
  - **permanent loss of benefits for the first offense involving the trading of firearms, ammunition, or explosives.**

If you make false or misleading statements about where you live to get duplicate food assistance or cash benefits, you may not be able to get food assistance or cash benefits for 10 years. In addition, if you make misleading statements about who you are to get duplicate food assistance benefits, you may not be able to get food assistance benefits for 10 years.

Interview


For food and/or cash assistance, we require an interview as part of the application process. An interview is not required for medical or child care, but you may ask for one.

☐ Your interview has been scheduled at: ->

☐ Your interview date and time is - Date: _____ Time: _____

☐ Please call for an interview appointment: _____

☐ Other: _____

Information Needed to Process Your Application




We may ask you to provide some or all of the following items. Please be ready to provide this information.

- Proof of where you live.
- Proof of age and identity.
- Proof of citizenship for those who want to receive benefits.
- Proof of non-citizen status for those who want to receive benefits
- Child care bills and receipts.
- Proof of child support and/or alimony paid or received.
- Proof of income (pay stubs, earning statements, rental property/sales contracts, government payments, Workers Compensation, pensions, and other).
- If self-employed, federal income tax returns, bookkeeping records, sales, and expenditure records.
- Life insurance, burial plans, and health insurance policies.
- Rent receipt/house payment (including insurance and property taxes).
- Proof of medical expenses for elderly or disabled persons, such as medication, doctor bills and hospital bills.
- Health insurance cards and premium information.
- Bank statements for checking accounts, savings accounts, or stocks/bonds/mutual funds.
- If anyone in the home is pregnant, provide verification of pregnancy with expected due date.
- Other: _____

If you have any questions, or need help completing the application, call us toll free at 1-888-369-4777.